Patient Label

# ADVANCED SURGICAL CONCEPTS
# CONSENT FOR PROCEDURE

You have a pain problem which has not been relieved by routine treatments. A procedure, specifically an injection or operation, is now indicated for further evaluation or treatment of your pain. There is **no guarantee** that a procedure will cure your pain, and in rare cases, it could become worse, even when the procedure is performed in a technically perfect manner. The degree and duration of pain relief varies from person to person, so after your procedure, we will reevaluate your progress, then determine if further treatment is necessary.

Your physician will explain the details of the procedure listed below. **Tell the physician if you are taking any blood thinners such as Coumadin, Lovenox or Heparin, as these can cause excessive bleeding** and a procedure should not be performed.

**THIS PARAGRAPH PERTAINS TO FEMALE PATIENTS ONLY - Anesthetic agents and x-rays can be harmful to the fetus of a pregnant woman. Anesthesia and x-rays should be avoided during pregnancy whenever possible. I hereby state that I am not pregnant and accept the responsibility of making this determination.**

**Alternatives** to the procedure include medications, physical therapy, behavior modification, surgery, etc.
**Benefits** include increased likelihood of correct diagnosis and/or of decrease or elimination of your pain.
**Risks** include infection, bleeding, allergic reaction, increased pain: nerve damage involving temporary or permanent pain, numbness, weakness, paralysis or death; air in lung requiring chest tube; tissue, bone or eye damage from steroids. Nerve destruction with phenol, Botox, alcohol, or radiofrequency energy have risks of nerve and tissue damage.
**Procedural risks** for each specific procedure are as follows (patient to initial line of procedure):

— **Epidural, Facet Joint, Medial Branch Nerve, Sacroiliac Joint, Transforaminal Epidural, Selective Nerve Root or Lumbar Sympathetic Injection/Block/Ablation(RF), Superior Hypogastric Block/Abaltion(RF), Splanchnic Nerve Block/Ablation(RF) Lumbar Puncture:** Low blood pressure, temporary weak/numb arm or leg, headache requiring epidural blood patch

— **Epidural Blood Patch:** Infection, back pain unrelieved headache

— **Peripheral Nerve Block, Occipital Nerve Block, Joint Injection:** Local pain from tissue and/or nerve irritation, dimpling of/depression in skin.

— **Discogram, Intradiscal Steroid Injection, IntraDiscal Electro Thermal Therapy (IDET) or Percutaneous discectomy:** Infection or discitis

— **Stellate Ganglion Block/Ablation:** Hoarseness, difficulty swallowing, seizure, weak and/or numb arm, air in lung

— **Intercostal Nerve Block, Intercoastal Nerve Ablation (RF):** Air in lung requiring chest tube in hospital, local pain from tissue and/or nerve irritation.

— **Spinal Cord Stimulator Trial, Spinal Cord Stimulator Implant:** Infection requiring hospitalization and removal of stimulator, catheter ; meningitis, nerve damage

— **Vertebroplasty:** Injury to the spinal cord or nerve roots, air in the lung requiring a chest tube and hospitalization.

— **Percutaneous Lysis of Epidural Adhesions:** Nerve damage, meningitis, dural puncture.

__ **IV Conscious Sedation (Versed, Sublimaize) :** Itching, nausea, low blood pressure, slowed breathing

__ **Monitored Anesthesia Care (Diprivan):** Slowed breathing, heart irregularities, low blood pressure, nausea, vomiting

The incidence of serious complications listed above requiring treatment is very low (less than 1% in our experience). Your physician believes the benefits of the procedure outweigh its risks or it would not have been offered to you, and it is your decision and right to accept or decline to have the procedure done.

I authorize _____ and such assistants as may be selected by him/her to perform the above initialed procedure:
I have read or had read to me the above information. I understand there are risks involved with this procedure, to include rare complications, even death, which may not have been specifically mentioned above. I accept them and consent to a (an)

_____

_____ and its associated risks.

_____ _____ _____
Patient or his/her legal guardian Signature Date Witness

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternative to, the proposed procedure/operation, have offered to answer any questions and have fully answered all such questions. I believe that the patient fully understands what I have explained and answered.

_____ _____
Physician Signature Date